(a) Medicaid reimbursement for services provided to an extraordinary recipient shall be the per diem rate plus a negotiated rate to cover the cost of medically necessary services and supplies that are not included in the per diem rate.

(i) The Department will negotiate with providers on a case-by-case basis to determine the negotiated rate and the billing procedures for extraordinary recipients.

(ii) Prior to such negotiations, the provider shall submit to the Department:

(A) A treatment plan; and

(B) A proposed reimbursement rate, including all relevant financial records and all medical records which document the medical necessity for services provided to an extraordinary recipient.

(iii) The Department may request, and the provider shall furnish before a negotiated rate is established, additional information to document the medical necessity for services provided to an extraordinary recipient.

(iv) The negotiated rate shall be the rate agreed upon by the provider and the Department for medically necessary services.

(v) The Department shall reevaluate the condition of an extraordinary recipient after the first fifteen days and at least every thirty days thereafter, and shall renegotiate the negotiated rate to reflect changes in the recipient's condition.

(b) All inclusive. The negotiated rate shall be an all inclusive reimbursement rate for all services and supplies furnished by the facility, except as specified in Section 24 and/or as otherwise agreed by the Department.

(c) Maximum rate. The negotiated rate shall not exceed the actual cost of the services provided to the extraordinary recipient.

(d) Until the Department agrees, in writing, to a negotiated rate, reimbursement for services provided to an extraordinary recipient shall be limited to the facility's per diem rate.

(e) The Department's refusal to agree to pay the rate requested by a provider for an extraordinary recipient is not an adverse action for purposes of Chapter 1.

(f) The facility shall maintain records of the costs it incurs in furnishing services to each extraordinary recipient. Costs related to services furnished to extraordinary recipients, other than nursing facility services, are not allowable costs for purposes of determining the facility's per diem rate.

Section 23. Contracted rate.

(a) The Department may pay a contracted rate to a facility that furnishes added value. The contracted rate may exceed the facility's per diem rate as determined pursuant to Section 17.

(b) The Department shall negotiate and enter into contracts for added value using the following procedures:

(i) Determine what constitutes added value, taking into consideration, for each facility, the factors specified in (A) and the objectives specified in (B):

(A) Factors:

(I) The average level of care furnished in the facility;

(II) The quality of care furnished in the facility;

(B) Objectives:

(I) Reduction in the number and frequency of institutionally acquired infections;

(II) Reduction in the number and frequency of adverse resident incidents, such as falls, skin tears, and wandering from the facility.

(III) Reduction in official and unofficial complaints;

(IV) Maintenance of residents' ideal body weight;

(V) Maintenance or improvement of facility survey results;

(VI) Maintenance of ambulatory levels of residents from admission to discharge;

(VII) Increases in the number of discharges to lesser acute settings; and

(VIII) Decreases in the incidence of residents' incontinence.

(ii) Solicit proposals for added value contracts; and

(iii) Negotiate with providers.

(c) The Department will negotiate with providers on an individual facility basis to determine whether a contracted rate is appropriate for that facility, using value added criteria developed for that facility.

(i) Prior to such negotiations, the provider shall submit to the Division, in the format prescribed by the Department:

(A) A proposed contracted rate; and

(B) Supporting documentation, including:

(I) All relevant financial records ~~Department~~ and medical records which demonstrate the added value the provider is or will be furnishing to recipients;

(II) A proposed method of collecting and evaluating clinical data to demonstrate that added value is being furnished, such method to be subject to review and approval by the Department; and

(III) The additional cost the facility will reasonably and necessarily be incurring to provide that added value.

(ii) The Department may request, and the provider shall furnish before a contracted rate is established, additional information to document the added value and/or added costs.

(iii) The contracted rate shall be the rate agreed upon by the provider and the Department. The rate shall apply to all recipients in the facility, unless otherwise agreed by the Department.

(iv) The Department may establish monitoring criteria and procedures to determine whether the added value is being furnished.

(v) If the Department determines that the value added criteria are not being satisfied, the Department shall reduce the facility's Medicaid reimbursement rate to the per diem rate established pursuant to Section 17. The decision to reduce a facility's contracted rate to a per diem rate shall not be an adverse action for purposes of reconsideration and/or Chapter 1.

(d) All inclusive. The contracted rate shall be an all inclusive per diem rate for all services and supplies furnished by the facility, except as specified in Section 24 and/or as otherwise agreed by the Department.

(e) Maximum rate. The negotiated rate shall not exceed the facility's actual costs.

(f) Until the Department agrees, in writing, to a contracted rate, reimbursement for services provided to recipients shall be limited to the facility's per diem rate.

(g) The Department's refusal to agree to a contracted rate requested by a provider is not an adverse action for purposes of Chapter 1.

Section 24. Medicaid allowable payment for Medicaid program services.

(a) The Medicaid allowable payment for Medicaid program services furnished to a recipient in a nursing facility shall be determined pursuant to the Attachments and policies of the Department.

(b) The Medicaid allowable payment for Medicaid program services furnished to an extraordinary recipient shall be determined pursuant to the Attachments and policies of the Department, except as otherwise agreed to by the Department and the facility pursuant to Section 22 or 23.

(c) Claims for Medicaid program services shall be submitted pursuant to the Attachments and policies of the Department.

Section 25. Billing requirements.

(a) Submission of claims. A provider seeking Medicaid reimbursement for services provided to a recipient must submit claims on the forms and in the manner specified by the Department.

(b) Medicaid payment as payment in full. A provider which receives or requests Medicaid payment for services and supplies included in the per diem rate must accept Medicaid payment as payment in full for such services and supplies. A provider may not attempt to collect or retain payment in addition to the per diem rate except as permitted by 42 C.F.R. § 483.10(c), which is incorporated by this reference, or other applicable federal law.

Section 26. Change in provider status.

(a) Termination of participation. If a provider's participation in the Medicaid program is terminated or suspended for any reason, the provider must submit a cost report for the period ending with the effective date of the termination or suspension. The cost report is due within forty-five (45) days after the date of termination or suspension, even though the provider's tax period does not end on the date of termination or suspension. The final month's payment due a provider shall be withheld until its cost report is filed and the Department has a reasonable time to perform a desk review and field audit of the cost report and patient funds account.

(b) Change of ownership.

(i) Notice of change of ownership. The parties to a transaction involving a change of ownership must notify the Department, in writing, of the proposed transaction no later than 60 days before the effective date of the change.

(ii) Representation agreement. Upon a change of ownership, all parties to the transaction shall have thirty days after the change to complete and sign a representation statement. If a representation statement is not timely submitted, both the original provider and any subsequent provider shall be jointly and severally responsible for all Medicaid liabilities which exist either before or after the change of ownership.

Section 27. Reimbursement of out-of-state providers.

(a) The reimbursement rate for out-of-state facilities providing services to Wyoming recipients shall be the lesser of:

(i) The Medicaid reimbursement rate the facility receives for the same or similar services from the Medicaid program in the state where the facility is located;

(ii) The average bed-weighted Medicaid rate in effect in Wyoming as of the previous July 1; and

(iii) The facility's usual and customary rate.

(iv) The average bed-weighted Medicaid rate in effect shall be determined by:

(A) Multiplying the number of licensed beds in each facility by the Medicaid per diem rate in effect for that facility;

(B) Adding the products determined pursuant to (B); and

(C) Dividing the sum determined pursuant to (B) by the total number of licensed beds in the state.

(b) No cost reports. An out-of-state provider need not submit cost reports to the Department.

(c) Billing requirements. An out-of-state provider must submit with each claim a certification of the provider's reimbursement rate under the Medicaid program in the state where the provider is located and the facility's usual and customary charge.

Section 28. Record retention.

(a) Providers shall comply with the Provider Records requirements of Chapter 3, which are incorporated by this reference.

(b) Explanation of records. In the event of a field audit, the provider shall have available at the field audit location one or more knowledgeable persons who can explain the provider's financial

records, the accounting and control system and cost report preparation, including attachments and allocations, to the auditors.

(c) Failure to maintain records. A provider unable to satisfy any of the requirements of this Section shall be given a written notice of deficiency and shall have sixty days after the date of the written notice to correct such deficiency. If, at the end of the sixty days, the Department determines that the deficiency has not been corrected, the Department shall withhold twenty-five percent (25%) of the provider's per diem rate for services provided on or after the sixtieth day. If, at the end of one hundred and twenty days after the mailing of the written notice of deficiency, the Department determines that the deficiency has not been corrected, the Department shall suspend all Medicaid payments for services provided after such date. Reimbursement shall not be reinstated until the Department determines that adequate records are being maintained. After the deficiency is corrected, the Department shall release any withheld payments.

(d) Out of state records. If a provider maintains financial or medical records out of state, the provider shall either transfer the records to an in-state location that is suitable for the Department to perform the field audit or reimburse the Department for reasonable costs, including travel, lodging and meals, incurred in performing the field audit in an out-of-state location.

Section 29. Repayment of credit balance.

(a) Report on cost report. A provider shall report a credit balance on the provider's cost report. A credit balance shall be repaid pursuant to (c).

(b) Annual request. The Department may request the repayment of any credit balance annually. Such request shall be made in writing and mailed by certified mail, return receipt requested. The provider shall repay the credit balance within sixty days after the date of receipt of the request for repayment.

(c) A provider shall repay any credit balance within sixty days after the date such credit balance is identified by the Department or the provider.

(d) Lump sum adjustment. If a credit balance identified pursuant to Sections (a) or (b) is not timely paid to the Department, the Department may recover the credit balance pursuant to Section 31.

Section 30. Audits.

(a) Field audits. The Department or HCFA may perform a field audit of a provider at any time to determine the accuracy and reasonableness of cost reports submitted by the provider and/or the validity of rate adjustment made pursuant to a desk review.

(b) Desk review. The Department or HCFA may perform a desk review of a provider at any time to determine the accuracy and reasonableness of cost reports submitted by the provider.

(c) The Department or HCFA may perform field audits or desk reviews through employees, agents, or through a third party. Audits shall be performed in accordance with GAAS.

(d) Disallowances.

(i) Nonallowable costs. If a field audit or desk review discloses nonallowable costs or costs for services and supplies not included in the per diem rate, the Department shall adjust the per diem rate retroactively to the beginning of the rate period in question, recover any excess payments pursuant to Section 31, and adjust the per diem rate for the remainder of the rate period.

(ii) Unsubstantiated cost.

(A) Upon written request by the Department, a provider must substantiate cost or other information reported on the provider's cost report. Substantiation must be provided, in writing, within thirty days after the date of the request.

(B) Any cost which a provider cannot substantiate shall be disallowed.

(C) Substantiation may include, but is not limited to, home office cost statement, resident census, statistical and related information, cost allocations, account analyses, invoices, stock ownership information, related parties' financial information, or subcontractor's financial information.

(iii) Financial or medical records which are not made available at the time of an audit shall not be admissible at an administrative hearing held pursuant to Section 32 unless the facility shows good cause for not making the records available at the time of the audit.

Section 31. Recovery of excess payments or overpayments..

(a) The Department may recover excess payments pursuant to Chapter 39, which is incorporated by this reference.

(b) The Department may recover overpayments pursuant to Chapter 16, which is incorporated by this reference.

Section 32. Reconsideration.

(a) Request for reconsideration. A provider may request that the Department reconsider a decision to recover excess payments, overpayments, or the determination of the provider's per diem rate. Such request must be mailed to the Department by certified mail, return receipt requested within twenty days of the date the facility receives notice pursuant to subsection 13(d) or Section 31. The request must state with specificity the reasons for the request. Failure to provide such a statement shall result in the dismissal of the request with prejudice.

(b) Reconsideration. The Department shall review the decision or rate and send written notice by certified mail, return receipt requested, to the provider of its final decision within forty-five days after receipt of the request for reconsideration or the receipt of any additional information requested pursuant to (c), whichever is later.

(c) Request for additional information. The Department may request additional information from the provider as part of the reconsideration process. Such a request shall be made in writing by certified mail, return receipt requested. The provider must provide the requested information within thirty days after the date of the request. Failure to provide the requested information shall result in the dismissal of the request with prejudice.

(d) Reconsideration shall be limited to whether the Department has complied with the provisions of this Chapter.

(e) Informal resolution. The provider or the Department may request an informal meeting before the final decision on reconsideration to determine whether the matter may be resolved. The substance of the discussions and/or settlement offers made pursuant to an attempt at informal resolution shall not be admissible as part a subsequent administrative hearing or judicial proceeding.

(f) Administrative hearing. A provider may request an administrative hearing regarding the final decision pursuant to Chapter 1 of these Attachments by mailing by certified mail, return receipt requested or personally delivering a request for hearing to the Department within twenty days of the date the provider receives notice of the final decision.

(g) Failure to request reconsideration. A provider which fails to request reconsideration pursuant to this section may not subsequently request an administrative hearing regarding the decision to recover excess funds or the per diem rate pursuant to Chapter 1.

(h) Matters not subject to reconsideration.

(i) The use or reasonableness of the reimbursement methodologies set forth in this Chapter;

(ii) A change in a payment rate caused by a change in the reimbursement methodology as the result of a change in state or federal law, including an amendment to this Chapter or other Attachments of the Department; or

(iii) The Department's refusal to agree to a negotiated rate or a contracted rate requested by a provider.

(i) Confidentiality of settlement agreements. If the Division and a provider enter into a settlement agreement as part of a reconsideration or an administrative hearing, such agreement shall

be confidential, except as otherwise required by law. A breach of confidentiality by the provider shall, at the Division's option, result in the settlement agreement becoming null and void.

Section 33. Superseding effect. When promulgated, this Attachment supersedes all prior Attachments or policy statements issued by the Department, including Manuals or Bulletins, which are inconsistent with this Attachment.

Section 34. Severability. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in effect.

WYOMING NURSING HOME REIMBURSEMENT SYSTEM

Addendum 1. Legislative Appropriation- 2000 Session

1. Appropriation for nursing wage increase effective July 1, 2000. The methodology to be used in reimbursing nursing facilities for the nursing wage increase effective July 1, 2000 is as follows:

(i) Prior to July 1, 2000, the Department will send out a survey document to all nursing facility providers requesting information regarding each facility's level of participation in the nursing wage increase.

(A) Facilities will have the opportunity to indicate on the document whether or not they wish to participate in the nursing wage increase.

(B) Facilities electing to participate will be asked to complete a schedule listing each employee receiving the increase, the average hours worked per week, the current wage rate, and the proposed wage rate after the increase.

(ii) Effective July 1, 2000, the allowable nursing wage increase amounts for each nursing facility will be calculated based on the response to the survey document. The nursing wage increase will be limited to the lesser of each facility's proposed increase, $1 per hour, or an allocation of the legislative appropriation.

(A) The per diem nursing wage increase for each facility, subject to the limits above, will be added to the healthcare limit of each facility's rate calculation.
(B) The per diem nursing wage increase for each facility, subject to the limits above, will also be added to the allowable per diem healthcare cost for each facility.
(C) Finally, the per diem nursing wage increase for each facility, subject to the limits above, will be added to the base rate used to establish the minimum and maximum rates in accordance with Section 17 (a).

(iii) In future rate setting periods, the nursing wage increase included in the healthcare component of the rate, as stated in (ii) (A) and (B) above, will be reduced by the portion of the cost report that extends beyond the July 1, 2000 effective date, since the cost report should already reflect these increased costs. The amount added to the base rate as specified under Addendum 1 will remain in the rate setting process until such time as the base rate reflects the cost increase.

(iv) In addition to the initial survey document, an additional schedule will be required with future cost reports ending after July 1, 2000 that will enable the Department to monitor the use of these funds. As stated in Section 21 (c), funds for which the facility cannot provide documentation shall be recovered pursuant to Section 31.